

2/9/10  
POCA accepted.  
B. Cawney

PRINTED: 01/19/20  
FORM APPROVE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVN010H	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/18/2009
NAME OF PROVIDER OR SUPPLIER  SOUTH LYON MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 940 YERINGTON, NV 89447		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
Z 000	Initial Comments  This Statement of Deficiencies was generated as a result of a State licensure survey conducted at your facility 11/16/09 through 11/18/09, in accordance with Nevada Administrative Code, Chapter 449, Skilled Nursing Facilities. The survey was conducted concurrently with the Medicare recertification survey.  The census was 47 residents. The sample size was 12 residents, which included one closed record.  A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.  Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  The following deficiencies were identified:	Z 000			
Z290 SS=G	NAC 449.74487 Nutritional Health; Hydration  1. Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that: (a) The nutritional health of the patient is maintained, including, without limitation, the	Z290			

RECEIVED

FEB 08 2010

BUREAU OF LICENSURE  
AND CERTIFICATION  
DEPARTMENT OF HEALTH

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE  
02/03/2010

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
Z290	<p>Continued From page 1</p> <p>maintenance of his weight and levels of protein, unless the nutritional health of the patient cannot be maintained because of his medical condition. (b) The patient receives a therapeutic diet if such a diet is required by the patient. This Regulation is not met as evidenced by: Based on record review, policy review, and interviews, the facility failed to ensure acceptable parameters of weight were maintained for 2 of 12 residents (Residents #4, #7), that a nutritional assessment was completed for 1 of 12 residents (Resident #8), and that care plans were developed and reviewed according to facility policy for all of the residents in the sample and that the duties of the dietitian were clearly defined and followed.</p> <p>Findings include:</p> <p>Resident #4</p> <p>Resident #4 was admitted to the facility on 6/4/09, with diagnoses including dementia, diabetes, hypertension, and gastroesophageal reflux disease.</p> <p>The minimum data set (MDS) indicated the resident had moderately impaired cognitive skills and needed supervision (oversight) with eating.</p> <p>Resident #4's weight upon admission (6/4/09) was 141 lbs. The progress note written on 6/25/09 by the facility's consultant dietitian, Employee #10, revealed that that resident lost 6 lbs in two weeks and health shakes were ordered to help with weight gain.</p> <p>Review of physician orders revealed that the health shakes were discontinued on 7/29/09, "due to overall weight gain." The resident's</p>	Z290	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>On 11-10-09, resident #4's diet texture was changed from regular to mechanical soft.</p> <p>On 11-17-09, health shakes were added three times a day for additional nutrition. Extra fluids (given with medications and in between meals) started being tracked and documented on the resident's Medication Administration Record.</p> <p>On 11-18-09, per our weight protocol, the resident's physician was notified. The physician's response included, "Wt. loss trend likely due to pt's advanced dementia." His care plan was updated to reflect this.</p>	11/10/09	11/17/09	11/18/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	
Z290	<p>Continued From page 2</p> <p>weight at this time was 146 lbs. Resident #4's weight upon admission (6/4/09) was 141 lbs. The resident's weight on the most recent MDS, dated 9/6/09, was 137 lbs. The resident's last nutritional assessment was conducted on 9/17/09, when the dietitian documented the following: "p.o. (by mouth) intake is fair to poor; appetite at 60% of meals; nutr. will continue to follow." A review of the resident's record revealed weights of 129.1 lbs on 9/30/09, and 128.4 lbs on 11/11/09, representing a 6.2% weight loss over a two-month period (between 9/6/09 and 11/11/09).</p> <p>The Activities of Daily Living (ADL) flow sheet, completed by Certified Nursing Assistants (CNAs), indicated that the resident's ability to eat declined from the categories of "Independent (0)" and "Supervision (1)" in September to "Limited Assistance (2)" and "Extensive Assistance (3)" in October. The last entry added to the resident's "Nutrition" care plan by Nursing was dated 9/2/09. There was no evidence in the record that this increased need in feeding assistance was care planned.</p> <p>Record review revealed that on 10/1/09, it was determined through laboratory blood draw that Resident #4 was suffering from dehydration and had to be admitted to the hospital to receive IV (intravenous) fluids. Upon the resident's return to the facility on 10/2/09, one of the physicians changed the resident's diet order to a low sodium, no added salt diet. This diet change was not updated in the Nutrition care plan, or documented in the Nutrition notes. No care plan addressing the resident's dehydration was developed by the either the dietitian or nursing staff.</p>	Z290	<p><b>Resident #4</b></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <p><b>The dietitian reviewed Resident #4 when she visited on 11-25-09.</b></p> <p><b>On 10-01-09, Resident was suffering from dehydration and was admitted to Acute to received IV fluids. On 10-02-09, another blood draw indicated the resident's hydration status had significantly improved.</b></p>	11/25/09  10/02/09	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	
Z290	<p>Continued From page 3</p> <p>According to the facility's "Hydration" policy, dated December 2005, "When it is determined by nursing, dietary, or the dietitian that a resident does not seem to be consuming sufficient fluids, or is exhibiting signs and symptoms of dehydration, the physician will be notified....An evaluation will be done to determine, if possible, the cause of the insufficient fluid intake. Laboratory studies will be evaluated...A care plan will be written that will include fluid goals, how the intake will be monitored, and suggested interventions."</p> <p>There was no evidence in the record that another blood draw had been ordered by the physician since 10/1/09, to reassess Resident #4's hydration status.</p> <p>On 11/17/09 at 11:30 AM, the dietitian was interviewed by phone. The dietitian indicated that she had not conducted a nutritional assessment on Resident #4 since 9/17/09, because Nursing had not alerted her to any weight-loss concerns. The dietitian further reported that Nursing was responsible for developing and updating care plans related to nutrition and dehydration.</p> <p>The dietary supervisor and risk manager, Employee #12, was interviewed on 11/17/09 at 12:00 PM. The supervisor explained that whenever the dietitian came to the facility (twice a month), Nursing gave her a weight chart for all residents, with current, 30-day, 90-day, and 180-day weights. The chart also included the calculated percentages of weight change for these time periods, with any significant weight loss being highlighted on the chart. A review of the chart revealed that the weight change</p>	Z290	<p><i>How you will identify other residents having the potential to be affected by the same practice and when anticipated corrective action will be taken:</i></p> <p>All new admissions' charts will be reviewed for a completed and timely dietitian assessment and recommendation weekly at the IDNN Committee Meeting.</p> <p>Through the "Resident Change Form" any changes noted will be communicated to the LTC Supervisor and the MDS Coordinator immediately by staff for documentation in the MDS and for care plan changes. Attachment #1</p> <p>Resident #4 A repeat BMP was done 10-02-09, and reflected improvement in his hydration status.</p> <p>Contract reviewed by Dietician and Administrator 12/18/09. RD will actively participate in IDNN committee in person every other week. On alternating weeks, information from the committee including minutes will be electronically communicated to her that day. For residents with changes in conditions or without positive results from interventions she will electronically make her recommendations within 48 hours. If not developed by her, all nutritional care plans will be reviewed and revised by her weekly. The IDNN Committee will review all residents thus including fractures, constipation, diarrhea, abnormal labs, fluid intake and UTI's as well as decubitus and ulcers, and tube feedings. Annual nutritional assessments will be completed on all residents by Jan 2010 and updated with any significant change in condition and on the original annual date.</p>	<p>12/18/09 &amp; weekly</p> <p>12/18/09</p> <p>10/02/09</p> <p>12/18/09</p> <p>01/31/10</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z290	<p>Continued From page 4</p> <p>percentage for Resident #4 was highlighted, showing that he had experienced a significant weight loss over the past 90 days.</p> <p>Review of the facility's "Unintended Weight Change" policy, dated December 1999, included the following statements: "Residents shall be routinely monitored for changes in their weight that are due to unintended causes. Unintended weight changes are those changes occurring for reasons other than weight reduction diets or calorie enhanced diets designed for weight gain.....The dietitian will review weights monthly and make recommendations to the nursing staff....An evaluation will be done to determine, if possible, the cause of the weight change..A care plan may be written that will include interventions to address the weight change..."</p> <p>A significant change reassessment, reflecting Resident #4's recent decline in weight, eating ability, and hydration status, was not conducted by the facility.</p> <p><b>Resident #7</b></p> <p>Resident #7 was admitted to the facility on 11/9/09, with diagnoses including dysphagia and osteoporosis. The resident had a gastrostomy tube and, because she was unable to consume anything by mouth due to severe aspiration, was receiving all of her nutritional needs from an enteral formula.</p> <p>The resident's admission weight was 81.2 lbs, down from 84 lbs a week earlier at the hospital. At 62 inches, the resident's ideal body weight (IBW) was 110 lbs, and upon admission to the facility, she was already only at 73.6% of her IBW. One week later, at the time of the survey</p>	Z290	<p><i>How you will identify other residents having the potential to be affected by the same practice and when anticipated corrective action will be taken:</i></p> <p><b>All new admissions' charts will be reviewed for a completed and timely dietitian assessment and recommendation weekly at the IDNN Committee Meeting.</b></p> <p><b>Through the "Resident Change Form" any changes noted will be communicated to the LTC Supervisor and the MDS Coordinator immediately by staff for documentation in the MDS and for care plan changes.</b></p> <p><b>Re: Resident #7: the dietitian assessment and recommendation was completed 11/1/09, when the resident was a Swing Bed patient. This was obtained from medical records and placed in the resident's current LTC chart. Re-reviewed on 12/18/09 with RD and Staff. Re-education on the difference in acute swing versus LTC charting requirements.</b></p>	<p>12/18/09 &amp; ongoing</p> <p>12/18/09</p> <p>11/01/09 &amp; 12/18/09</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	
Z290	<p>Continued From page 5</p> <p>on 11/17/09, Resident #7's weight was 78.7 lbs (71.5% of IBW), representing a 3.1 % weight loss over a one week period.</p> <p>Record review revealed a note in the resident's record, written by Nursing on 11/9/09, which read, "new G tube, weight loss 5# over one week, maybe related to new GTF." Review of the resident's record further indicated that Nursing had completed and faxed an initial nutritional screening form to the dietitian on 11/9/09. There was no evidence in the record that the dietitian faxed back a completed "Dietitian Assessment and Recommendation Form," as directed in the facility's "Nutritional Assessment Program" policy dated December 2008. There was also no evidence that a more in-depth "Nutritional Assessment" form was completed by the dietitian within seven days, as outlined in the same policy.</p> <p>An interview was conducted with the consultant dietitian by phone on 11/18/09 at 8:40 AM. The dietitian indicated that she was in the facility on 11/12/09 but had not been alerted by Nursing for the need to assess the nutritional status of Resident #7. The dietitian further explained that she was under the assumption that since she had conducted a nutritional assessment for the resident on 11/1/09, at the hospital she did not need to complete an initial nutritional assessment when the resident was admitted to the facility on 11/9/09.</p> <p>Resident #8</p> <p>Resident #8 was admitted to the facility on 9/3/09, following a hospital stay due to a fracture of her fibula and tibia. She had additional</p>	Z290	<p>Contract reviewed by Dietician and Administrator 12/18/09. RD will actively participate in IDNN committee in person every other week. On alternating weeks, information from the committee including minutes will be electronically communicated to her that day. For residents with changes in conditions or without positive results from interventions she will electronically make her recommendations within 48 hours. If not developed by her, all nutritional care plans will be reviewed and revised by her weekly. The IDNN Committee will review all residents thus including fractures, constipation, diarrhea, abnormal labs, fluid intake and UTI's as well as decubitus and ulcers, and tube feedings. Annual nutritional assessments will be completed on all residents by Jan 2010 and updated with any significant change in condition and on the original annual date.</p> <p>Re: Resident #8: No dietician assessment and recommendation was found. This resident was discharged home on 11-04-09 and the chart is closed. Although upon closer review of her chart her admit weight was a stated weight by the resident as she was unable to be weighed at the time of admission, therefore it was not accurate.</p>	01/31/10	11/04/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVN010H	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/18/2009
NAME OF PROVIDER OR SUPPLIER  SOUTH LYON MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 940 YERINGTON, NV 89447		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z290	<p>Continued From page 6</p> <p>diagnoses of Multiple Sclerosis, depression and a urinary tract infection. She was confined to a wheelchair. Discharge to home on 11/4/09.</p> <p>Two forms, the South Lyon Medical Center LTC Dietician Assessment and Recommendation form and the Nutrition Progress Note were located in the resident's chart. Neither had been filled out. A Interdisciplinary Initial Care Conference note, dated 9/15/09, indicated that Resident #8's current diet was a regular diet with thin liquids and that she required supervision with eating. The documentation further indicated that Resident #8 had a 10 pound weight loss since admission, 12 days earlier.</p> <p>Facility Policy, Nutritional Assessment Program, effective 12/2008, stated that the Consultant Dietician must complete the Nutritional Assessment within seven days of admission. There was no evidence that Resident #8 had been seen by the dietician at any time during her admission.</p> <p>During an interview with Employees #6 and #13 on 11/17/09, it was disclosed that Nursing had been directed by Administration that all nutritional care plans were to be developed by the nursing staff. There was no evidence that the developed care plans were reviewed or revisited by the dietician.</p> <p>Review of an undated Dietary Services Contract Agreement, signed by the dietician, stated that the dietician would develop appropriate care plans to meet individual needs. The contract stipulated that she would spent 12 hours a month at the long term care unit. In a telephone interview with the dietician on 11/17/09 at 11:20 AM, she confirmed that she did not developed</p>	Z290	<p>How you will identify other residents having the potential to be affected by the same practice and when anticipated corrective action will be taken:</p> <p>All new admissions' charts will be reviewed for a completed and timely dietician assessment and recommendation weekly at the IDNN Committee Meeting.</p> <p>Through the "Resident Change Form", any changes noted will be communicated to the LTC Supervisor and the MDS Coordinator immediately by staff for documentation in the MDS and for care plan changes. Re education of staff on facility policy and procedures on Hydration and nutrition will occur by January 10, 2010.</p> <p>Contract reviewed by Dietician and Administrator 12/18/09. RD will actively participate in IDNN committee in person every other week. On alternating weeks, information from the committee including minutes will be electronically communicated to her that day. For residents with changes in conditions or without positive results from interventions she will electronically make her recommendations within 48 hours. If not developed by her, all nutritional care plans will be reviewed and revised by her weekly. The IDNN Committee will review all residents thus including fractures, constipation, diarrhea, abnormal labs, fluid intake and UTI's as well as decubitus and ulcers, and tube feedings. Annual nutritional assessments will be completed on all residents by Jan 2010 and updated with any significant change in condition and on the original annual date.</p> <p>What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur:</p> <p>"Process changed to assure any change in condition is communicated to the LTC supervisor and the MDS Coordinator through the development of the "Resident Change Form".</p> <p>Re-education of all staff by Nursing Education on facility policy and procedure on Hydration and Nutrition. Attachment #2</p>	<p>2/21/09</p> <p>01/10/10</p> <p>2/18/09</p> <p>1/31/10</p> <p>12/21/09</p> <p>01/10/10</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
Z290	<p>Continued From page 7</p> <p>resident nutritional care plans, but that she reviewed the care plan after its development.</p> <p>The dietician also disclosed that she was involved with resident evaluations for all new admissions, specific referrals from the physicians or nursing staff, residents with weight loss or gain and residents with skin conditions. She did not normally become involved with residents with fractures, constipation, diarrhea, abnormal laboratory values, poor fluid intake or urinary tract infections. Nursing staff confirmed that they did not fax abnormal lab values to the dietician. Nutritional progress notes stated that the dietician would monitor the intake of oral fluids, but there was no evidence that this was being done. The dietician did not assess every resident monthly, but did do quarterly assessments.</p> <p>In the interview with Employee #6 and #13 on 11/17/09, it was disclosed that there was no expectation for the dietician to participate in the care of residents other than new admissions, weight problems, skin conditions or direct referrals. The nursing staff indicated that they went directly to the physicians with many dietary or dietary associated needs, like dehydration and abnormal lab values. It was not anticipated that the dietician would do annual nutritional assessments. Several of the residents had not had an annual assessment since 2007. The policy, Nutritional Assessment Program, indicated that the Nutritional Assessment was to be reviewed and updated by the dietician yearly or in the event of a significant change in the resident.</p> <p>Severity 3 Scope 1</p>	Z290	<p><i>* Implement the short term nursing care plans for newly identified issues such as potential for dehydration.</i></p> <p><i>* The development of the IDNN Committee - see attached charter.</i></p> <p>The formation of the IDNN Committee - see attached charter and minutes from initial meeting held December 18, 2009. This committee will review all residents to assure:</p> <p>nutritional assessments have been completed in a timely fashion on all residents new - or with significant changes</p> <p>annual assessments or reassessments upon change of condition</p> <p>review all residents for weight loss or gain</p> <p>review all residents with any change in nutritional needs including assistance eating, assistive devices, or change in appetite or eating habits</p> <p>review all residents with any decubitus or skin ulcers</p> <p>review all residents with actual or potential elimination issues including constipation and diarrhea or urinary elimination issues or changes</p> <p>review all residents with infectious processes including UTI</p> <p>review all residents suffering nausea or vomiting</p> <p>review all residents abnormal laboratory values as they relate to nutritional health</p> <p>review all residents for any hydration or nutritional concerns</p> <p>Four Long LTC staff members to attend HCPRO LTC Boot camp February 22-25, 2010.</p> <p>On site evaluation and recommendation made by 5 star rural LTC QA/RM nurse</p> <p>This IDNN committee to meet weekly to review all residents nutritional and hydration status.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.</p> <p>Weekly review through the IDNN Committee.</p> <p>Individual Responsible: LTC Supervisor Date of Completion: 02-04-10 Attachment #3</p>	<p>12/21/09</p> <p>12/18/09</p> <p>2/25/10</p> <p>1/12/10</p> <p>02/04/10</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.



Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z291	Continued From page 8	Z291		
Z291 SS=G	<p>NAC449.74487 Nutritional Health; Hydration</p> <p>2. A facility for skilled nursing shall provide each patient in the facility with sufficient fluids to maintain proper hydration and health.</p> <p>This Regulation is not met as evidenced by: Based on record review, policy review, and interview, the facility failed to ensure that 1 of 12 residents (Resident #4) received a sufficient amount of fluids to prevent dehydration.</p> <p>Findings include:</p> <p>Resident #4 was admitted to the facility on 6/4/09, with diagnoses including dementia, diabetes, hypertension, and gastroesophageal reflux disease.</p> <p>The resident's weight upon admission (06/04/09) was 141 lbs. A progress note written on 6/25/09 by the facility's consultant dietitian, Employee #10, revealed that that resident lost 6 lbs in two weeks and health shakes were ordered to help with weight gain.</p> <p>Review of physician orders revealed that the healthshakes were discontinued on 7/29/09, "due to overall weight gain." The resident's weight at this time was 146 lbs. The resident's weight on the most recent MDS, dated 9/6/09, was 137 lbs. The resident's last nutritional assessment was conducted on 9/17/09, when the dietitian documented the following: "p.o. (by mouth) intake is fair to poor; appetite at 60% of meals; nutr. will continue to follow." A review of the record revealed that the resident's weight on 9/30/09 was 129.1 lbs, representing a 5.7% weight loss over a one-month period (between</p>	<p>Z291</p> <p><i>What corrective actions(s) will be accomplished for those resident found to have been affected by the deficient practice:</i></p> <p>On 11-10-09, resident #4's diet texture was changed from regular to mechanical soft.</p> <p>On 11-17-09, health shakes were added three times a day for additional nutrition. Extra fluids (given with medications and in-between meals) started being tracked and documented on the resident's Medication Administration Record.</p> <p>On 11-18-09, per our weight protocol, the resident's physician was notified. The physician's rezones included, "Wt. loss trend likely due to pt's advanced dementia." His care plan was updated to reflect this.</p> <p>On 10-01-09, Resident was suffering from dehydration and was admitted to Acute to receive IV fluids. On 10-02-09, another blood draw indicated the resident's hydration status had significantly improved.</p> <p>All current residents have been reviewed for risk for dehydration. Those found to be at risk will have the extra fluids (given with medications and in-between meals) tracked and documented on the MAR. These residents have been discussed in the Interdisciplinary Dietary Nursing Nutrition Committee (IDNN) committee and totaled intakes were reviewed with physician and dietitian.</p> <p><i>What corrective actions(s) will be accomplished for those resident found to have been affected by the deficient practice:</i></p> <p>The dietitian reviewed Resident #4 when she visited on 11-25-09.</p> <p>Resident #4's care plan was updated to reflect the dietitian's recommendations.</p> <p>Resident #4 - A repeat BMP was done 10-02-09, and reflected improvement in his hydration status.</p>	<p>11/10/09</p> <p>11/17/09</p> <p>11/18/09</p> <p>10/02/09</p> <p>1/31/10</p> <p>11/25/09</p> <p>10/02/09</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z291	<p>Continued From page 9</p> <p>9/6/09 and 9/30/09). There were no subsequent entries in the record by the dietitian, and there was no evidence that any interventions were attempted by the facility to reverse the resident's weight loss.</p> <p>Record review revealed that on 10/1/09, it was determined through laboratory blood draw that Resident #4 was suffering from dehydration and had to be admitted to the hospital to receive IV (intravenous) fluids. Upon the resident's return to the facility on 10/2/09, one of the physicians changed the resident's diet order to a low sodium, no added salt diet. This diet change was not updated in the Nutrition care plan, or documented in the Nutrition notes. No care plan addressing the resident's dehydration was developed by the either the dietitian or nursing staff. Daily fluid intake was being recorded on meal intake sheets by Certified Nursing Assistants (CNAs) in the dining room, but fluids were not being monitored in-between meals, including at med pass and snack times.</p> <p>According to the facility's "Hydration" policy, dated December 2005, "When it is determined by nursing, dietary, or the dietitian that a resident does not seem to be consuming sufficient fluids, or is exhibiting signs and symptoms of dehydration, the physician will be notified....An evaluation will be done to determine, if possible, the cause of the insufficient fluid intake. Laboratory studies will be evaluated...A care plan will be written that will include fluid goals, how the intake will be monitored, and suggested interventions."</p> <p>There was no evidence in the record that another blood draw had been ordered by the physician since 10/1/09 to reassess the resident's hydration</p>	Z291	<p><i>What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur:</i></p> <p>*Process changed to assure any change in the condition is communicated to the LTC supervisor and the MDS Coordinator through the development of a "Resident Change Form".</p> <p>*Re-education of all staff by Nursing Educator on facility policy and procedure on Hydration and Nutrition.</p> <p>* Implement the short term nursing care plans for newly identified issues such as potential for dehydration.</p> <p>* The development of the IDNN Committee - see attached charter.</p> <p>The formation of the IDNN Committee - see attached charter and minutes from initial meeting held December 18, 2009. This committee will review all residents to assure:</p> <p>nutritional assessments have been completed in a timely fashion on all residents new - or with significant changes</p> <p>annual assessments or reassessments upon change of condition</p> <p>review all residents for weight loss or gain</p> <p>review all residents with any change in nutritional needs including assistance eating, assistive devices, or change in appetite or eating habits</p> <p>review all residents with any decubitus or skin ulcers</p> <p>review all residents with actual or potential elimination issues including constipation and diarrhea or urinary elimination issues or changes</p> <p>review all residents with infectious processes including UTI</p> <p>review all residents suffering nausea or vomiting</p> <p>review all residents abnormal laboratory values as they relate to nutritional health</p> <p>review all residents for any hydration or nutritional concerns</p>	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN010H</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LYON MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 940 YERINGTON, NV 89447</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
Z291	Continued From page 10  status.  On 11/17/09 at 11:30 AM, the dietitian was interviewed by phone. The dietitian indicated that she had not conducted a nutritional assessment on Resident #4 since 9/17/09, because Nursing had not alerted her to any concerns. The dietitian further reported that Nursing was responsible for developing and updating care plans related to nutrition and dehydration.  Severity 3 Scope 1	Z291	<p>Four Long LTC staff members to attend HCPRO LTC Boot camp February 22-25, 2010.</p> <p>On site evaluation and recommendation made by 5 star rural LTC QA/RM nurse on January 12, 2010.</p> <p>This IDNN committee to meet weekly to review all residents nutritional and hydration status.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.</p> <p>Weekly review through the IDNN Committee.</p> <p>Contract reviewed by Dietician and Administrator 12/18/09. RD will actively participate in IDNN committee in person every other week. On alternating weeks, information from the committee including minutes will be electronically communicated to her that day. For residents with changes in conditions or without positive results from interventions she will electronically make her recommendations within 48 hours. If not developed by her, all nutritional care plans will be reviewed and revised by her weekly. The IDNN Committee will review all residents thus including fractures, constipation, diarrhea, abnormal labs, fluid intake and UTI's as well as decubitus and ulcers, and tube feedings. Annual nutritional assessments will be completed on all residents by Jan 2010 and updated with any significant change in condition and on the original annual date.</p>	<p>02/25/10</p> <p>01/12/10</p> <p>12/18/09 &amp; ongoing</p> <p>12/18/09</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.